U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue Date: 18 December 2002

CASE NO.: 2001-BLA-1080
2001-BLA-1081

In the Matter of

EVELYN PRICE Survivor of and on behalf of JAMES H. PRICE,
Claimant

v.

SOUTHERN APPALACHIAN COAL INC.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Otis R. Mann, Esquire
For the Claimant

David L. Yaussy, Esquire
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER AWARDING LIVING MINER'S BENEFITS AND DENYING SURVIVOR'S BENEFITS

This proceeding arises from a claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* [1] ("Act"), filed on March 24, 1999. (DX 1).[2] The Act and implementing

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The amended Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the Part 725 regulations, however, were to apply only to claims filed on or after January 19, 2001, *not* to pending cases. The Amendments to the Part 718 and 725 regulations were challenged in a lawsuit filed in the United States District Court for the District of Columbia in

regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;

2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers pneumoconiosis" "CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The above-captioned claim is a consolidated duplicate miner's claim and a survivor's claim for benefits. The claimant's prior claim for benefits was filed on August 9, 1986. (DX 30-1). The claim was informally denied on November 6, 1986. (DX 30-8). The present duplicate claim for benefits was filed on March 24, 1999. (DX 1). An Initial Finding of Entitlement was issued by the District Director on August 5, 1999. (DX 19). Thereafter, counsel for employer objected to the District Director's findings and requested a formal hearing. (DX 26).

On September 7, 2000, Mr. Price died. On October 17, 2000, Evelyn Price, filed a survivor's claim for benefits and the employer then moved to consolidate both claims. (DX 41, 43). On May 24, 2001, the claims were consolidated by the District Director. (DX 62).

I was assigned this case on May 31, 2001. On September 17, 2002, I held a hearing in Charleston, West Virginia. At the hearing Director's Exhibits (DX) 1 through 64, Claimant's Exhibits (CX) 1 through11, and Employer's Exhibit (EX) 1 were submitted to the record.

National Mining Association v. Chao, No. 1:00CV03086 (EGS). On February 9, 2001, the District Court issued a Preliminary Injunction Order which enjoined the application of the Amendments "except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of the case." On August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor's motion for summary judgment in *National Mining Association v. Chao*, dissolved the Preliminary Injunction, and upheld the validity of the amended regulations.

[2] The following abbreviations are used for reference within this opinion: DX-Director's Exhibits; CX- Claimant's Exhibit; EX- Employer's Exhibit; TR- Hearing Transcript; Dep.- Deposition.

ISSUES

I. Whether the decedent-miner had pneumoconiosis as defined by the Act and the Regulations?

II. Whether the decedent-miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the decedent-miner was totally disabled?

IV. Whether the decedent-miner's disability was due to pneumoconiosis?

V. Whether there has been a material change in condition?

VI. Whether decedent-miner's death was caused by pneumoconiosis?

FINDINGS OF FACT

I. Background

A. Coal Miner

The parties agree and I find that the claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least seventeen (17) years. (DX 2, DX 3). [3]

B. Date of Filing

The parties agree and I find that the claims were timely filed**.** (TR 7).

C. Responsible Operator

The parties agree and I find that Southern Appalachian Coal Company (hereinafter "Southern") is the last employer for whom the claimant worked a cumulative period of at least one year and it is the properly designated responsible coal mine operator in this case, under

[3] Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust is determinative of the circuit court's jurisdiction. Since the decedent-miner was employed in West Virginia, Fourth Circuit law applies.

Subpart F (Subpart G for claims filed on or after Jan. 19, 2001), Part 725 of the Regulations.[4] The parties further stipulated that American Electric Power Company is the parent company of Southern and does not qualify as a coal mine operator under the Black Lung Act. (TR 8).

D. Dependents

The parties agree and I find that the decedent-miner has one dependent has one dependent for purposes of augmentation, his surviving wife, Evelyn K. Price. (DX 48).

E. Personal and Employment History

The decedent-miner was born on October 27, 1932. (DX 1). He married Evelyn Price in 1965. (TR 13). He was employed as a coal miner until 1982. (TR 14). He smoke cigarettes for approximately forty years, with periods of cessation. (TR 21). In 1999 he was diagnosed with lung cancer, which metastasize in his brain. (TR 16-17). Despite undergoing a right upper lobectomy and radiation and chemotherapy, Mr. Price died on September 7, 2000. *Id.*, *See also* DX 50.

II. Medical Evidence

A. Chest X-rays

In the present matter forty one X-ray readings of eight X-rays, from October 9, 1986 to November 27, 1999, were submitted. Of the forty one readings, twenty five readings were interpreted as negative for pneumoconiosis and sixteen readings were interpreted as positive for pneumoconiosis. In addition, four CT scan readings, of one CT scan dated October 12, 1999, were submitted. A summary of the X-ray evidence is contained in Appendix "A".

B. Pulmonary Function Studies

Pulmonary Function Tests are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated

---

[4] 20 C.F.R. § 725.492. The terms "operator" and "responsible operator"are defined in 20 C.F.R.§ § 725.491 and 725.492. The regulations provide two rebuttable presumptions to support a finding the employer is liable for benefits: (1) a presumption that the miner was regularly and continuously exposed to coal dust; and (2) a presumption that the miner's pneumoconiosis **(disability or death and not pneumoconiosis for claims filed on or after Jan. 19, 2001)** arose out of his employment with the operator. 20 C.F.R. §§ 725.492(c) and 725.493(a)(6) (§§ 725.491(d) and 725.494(a) for claims filed on or after Jan. 19, 2001). To rebut the first, the employer must establish that there were *no* significant periods of coal dust exposure. *Conley v. Roberts and Schaefer Coal Co.*, 7 B.L.R. 1-309 (1984); *Richard v. C & K Coal Co.*, 7 B.L.R. 1-372 (1984); *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). To rebut the second, the operator must prove "within reasonable medical certainty or at least probability by means of fact and/or expert opinion based thereon that the claimant's exposure to coal dust in his operation, at whatever level, did not result in, or contribute to, the disease." *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). Neither presumption has been rebutted in this case.

examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician Date Exh.#	**Age Height**	**FEV_1**	**MVV**	**FVC**	**Trac-ing**	**Compre-hension Cooper-ation**	**Qualify* Conform****	**Dr.'s Impression**
Gaziano 10/9/86 DX 30-4	53	69"	2.66	65	4.09	Good Good	No* Yes**	
Walker 6/4/99 DX 9 Pre-Bronchodilator	66 68"	1.48	50	3.48	Yes	Good Good	Yes* Yes**	
Walker 6/4/99 DX 9 Post-Bronchodilator	66 68"	1.64	72	3.61	Yes	Good Good	Yes* Yes**	
Zaldivar 9/22/99 DX 25 Pre-Bronchodilator	68" 66***	1.26	52	2.67	Yes	Good Good	Yes* Yes**	
Zaldivar 9/22/99 DX 25 Post-Bronchodilator	68" 66	1.34	65	2.95	Yes	Good Good	Yes* Yes**	

* A "**qualifying"** pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). (*see Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

***Mr. Price incorrectly reported his age as 60 to Dr. Zaldivar. His actual age at the time of the test was 66.

For a miner of the claimant's height of 68 inches, § 718.204(c)(1) requires an FEV_1 equal to or less than 1.79 for a male 66 years of age. If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.32 or an MVV equal to or less than 72; or a ratio equal to or less than 55% when the results of the FEV1 test are divided by the results of the FVC test. Qualifying values for other ages and heights recorded are depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	**Age**	**FEV_1**	**FVC**	**MVV**
69"	53	2.11	2.67	84

C. Arterial Blood Gas Studies[5]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex.#	**Physician**	**pCO_2**	**pO_2**	**Qualify**	**Physician Impression**
10/9/86 DX 30-8 Rest	Gaziano	35	89	No	
10/9/86 DX 30-8 Exercise	Gaziano	35	83	No	
6/4/99 DX 9	Walker	39	68	No	
9/22/99 DX 25 Rest	Zaldivar	38	62	Yes	
9/22/99 DX 25 Exercise	Zaldivar	39	67	No	

+ Results, if any, after exercise. Exercise studies are not required if medically contraindicated.

[5] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. § 718.204(c) permits the use of such studies to establish "total disability." It provides:
In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (c)(1), (2), (3), (4), or (5) of this section shall establish a miner's total disability: . . .
(2) Arterial blood gas tests show the values listed in Appendix C to this part . . .

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4).

On June 4, 1999, James H. Walker, M.D., examined the claimant. (DX 11). Dr. Walker initially noted Mr. Prices over thirty years of coal mine employment and his long standing smoking habit of twenty cigarettes a day. However, Dr. Walker did note that Mr. Walker quit smoking several years ago. In addition, Dr. Walker noted that Mr. Price's complaints included wheezing, chronic cough with sputum and shortness of breath.

Dr. Walker examined the claimant and ordered a chest X-ray, arterial blood gas test, and a pulmonary function test. Dr. Walker noted that Mr. Price appeared older than his stated age and suffered from confusion. Dr. Walker opined that Mr. Price's X-ray showed evidence of coal workers' pneumoconiosis, with a cavitary lesion in the upper right lobe. Dr. Walker added that Mr. Price's pulmonary function study showed severe obstruction ventilatory defect with minimal response of the FEV1 after the use of bronchodilators. As a result of his examination, Dr. Walker concluded that Mr. Price has coal workers' pneumoconiosis and that he suffers from a respiratory disability as a result of his pneumoconiosis and his cigarette smoking, which prevents him from returning to his work as a coal miner.

On September 22, 1999, George L. Zaldivar, M.D., examined the claimant. In a report dated November 23, 1999, Dr. Zaldivar submitted his findings. (DX 25). Dr. Zaldivar is a B-reader and is board-certified in pulmonary diseases and internal medicine. Dr. Zaldivar initially noted Mr. Price's coal mine employment history and his prior, but long standing smoking habit.

Dr. Zaldivar concluded that Mr. Price does have pneumoconiosis, as a result of his coal mine dust exposure. Dr. Zaldivar performed a breathing test and an exercise test. Dr. Zaldivar noted that the results were puzzling, in that Mr. Price's exercise test was basically normal other than the reported hypoxemia, but the breathing test showed a moderate, but disabling respiratory impairment. Dr. Zaldivar opined that these results indicate that Mr. Price's ventilatory impairment is not a fixed abnormality. Dr. Zaldivar concluded that Mr. Price's pulmonary impairment "is attributable, for the most part, to his past smoking habit and to some degree to his occupational pneumoconiosis." Dr. Zaldivar reasoned that Mr. Price's occupational pneumoconiosis is "early", while Mr. Price's smoking habit been present for many years and in itself is sufficient to cause disabling and even fatal emphysema. Additionally, Dr. Zaldivar opined that Mr. Price must have some asthmatic component to the obstruction, which was treated with the bronchodilators, which allowed him to perform well during the exercise test. Finally, Dr. Zaldivar noted that the mass in Mr. Price's lung has destroyed 1/3 of his right lung and has contributed to his respiratory impairment.

Like Dr. Walker, Dr. Zaldivar was also concerned by the cavitary mass seen in Mr. Price's chest X-ray. Dr. Zaldivar opined that the mass could likely be cancer. However, Dr. Zaldivar added that even if it was cancer, he did not believe it was in any way related his pneumoconiosis.

In a supplemental report, dated April 25, 2000, Dr. Zaldivar changed his conclusion. (DX 35). More specifically, Dr. Zaldivar reviewed a chest X-ray take after Mr. Price's lobectomy and noted that the nodules that he saw before the lobectomy were no longer present. Dr. Zaldivar added that the nodules must have been an inflammatory disease, because the nodules could not have disappeared after a lobectomy. Accordingly, Dr. Zaldivar concluded that Mr. Price does not have coal workers' pneumoconiosis, and therefore, pneumoconiosis in no way contributed to Mr. Price's respiratory impairment.

At the request of counsel for the employer, Robert B. Altmeyer, M.D. reviewed Mr. Price's medical records and physician reports. In a report dated September 16, 2002, Dr. Altmeyer submitted his findings. Dr. Altmeyer is a B-reader and is board certified in internal medicine and pulmonary diseases.

Based upon his review of Mr. Price's medical records, Dr. Altmeyer opined that Mr. Price did not have pneumoconiosis. Dr. Altmeyer reasoned that Dr. Zaldivar's CT scan did not show evidence of pneumoconiosis. In addition, Dr. Altmeyer stated that Mr. Price's fluctuating X-ray readings are inconsistent with pneumoconiosis, since pneumoconiosis causes permanent damage. Moreover, Dr. Altmeyer noted that Mr. Price's wheezing on forced exhalation and rhonchi are inconsistent with a diagnosis of pneumoconiosis, but are rather more consistent with COPD caused by smoking. Dr. Altmeyer added that Mr. Price had a long standing smoking history. Most significantly, Dr. Altmeyer noted that Mr. Price's pathology report showed no evidence of silicosis, a finding that would indicate pneumoconiosis. Furthermore, Dr. Altmeyer concluded that Mr. Price did not have a pulmonary impairment, but only a moderate degree of airway obstruction from his prior tobacco smoking. Accordingly, Dr. Altmeyer did not find that coal workers' pneumoconiosis hastened Mr. Price's death or caused him to suffer from a total respiratory disability.

On March 28, 2001, Mohammed I. Ranavaya, M.D., reviewed Mr. Price's medical records. (DX 54). Dr. Ranavaya is board certified in preventive medicine. Based upon a review of Mr. Price's medical records, Dr. Ranavaya concluded that Mr. Price had pneumoconiosis, but that he did not have a total respiratory disability. Dr. Ranavaya further opined that Mr. Price did not have a total respiratory disability due to pneumoconiosis, nor was his death caused by pneumoconiosis. However, Dr. Ranavaya provided no explanation for his reasoning and merely provided "yes" and "no" answers for each issue regarding entitlement.

The claimant's hospitalization records from Thomas Memorial Hospital were also submitted. (DX 50). On October 19, 1999, Mr. Price had a lobectomy of his right lung to remove the cancer mass seen in his right upper lobe. The records further indicate that on October 25, 1999, Mr. Price sought radiation treatment for his cancer, which had metastasize in his brain.

On November 6, 1999, Mr. Price was admitted to the hospital after having a seizure.

Included in the hospitalization records, is a pathology report, dated October 21, 1999, by Richard M. Faulks, M.D. The pathology report showed evidence of anthracosis in Mr. Price's lymph nodes and right upper lobe.

E. Death Certificate

The claimant, Mr. Price, died on September 7, 2000. (DX 49). The cause of death noted on his death certificate was cancer of the lung. The death certificate was issued by the West Virginia Department of Health, by Gary L. Thompson. No autopsy report was submitted.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205*; Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

B. Material Change in Conditions

Since this is a duplicate claim for benefits, he must initially show that there has been a material change of conditions.[6] To assess whether a material change in conditions is established, the Administrative Law Judge ("Administrative Law Judge") must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996) (*en banc*); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994); and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995). *See Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits. *Sharondale*

---

[6] Section 725.309(d) provides, in pertinent part:

> In the case of a claimant who files more than one claim for benefits under this part, . . . [i]f the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the [Director] determines there has been a material change in conditions . . . (Emphasis added).

Corp. v. Ross, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995).

In *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995), *aff'd.*, 86 F.3d 1358 (4th Cir. 1996)(en banc), *cert. denied*, 117 S. Ct. 763 (1997), the Fourth Circuit rejected the Board's *Spese* standard for establishing a "material change in conditions" in a subsequent claim. *Id.* at 406. The court determined that "[t]he purpose of section 725.309(d) is not to allow a claimant to revisit an earlier denial of benefits, but rather only to show that his condition has materially changed since the earlier denial." *Id.* at 406. As such, the court concluded that *Spese* "is an impermissible reading of section 725.309(d)." *Id.* at 406. In its en banc review of the case, the court concluded that it would apply the standard set forth by the Sixth Circuit's position in *Sharondale* for establishing a "material change in conditions" which requires that the judge must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements previously adjudicated against him. The Fourth Circuit declined, however, to adopt the Sixth Circuit's additional requirement that the judge examine the evidence underlying the prior denial to determine whether it "differ[s] qualitatively" from that which is newly submitted.

The decedent-miner's prior application for benefits was denied because the evidence failed to show that: (1) the claimant had pneumoconiosis; (2) the pneumoconiosis arose, at least in part, out of coal mine employment; and (3) the claimant was totally disabled by pneumoconiosis. Under the *Sharondale* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits. *LaBelle Processing*, 72 F.3d. at 318. Since I have found that the decedent-claimant has established an element of entitlement, specifically that he had coal workers' pneumoconiosis and that he suffered from a total respiratory disability, I have reviewed all the evidence of record.

C. Existence of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." [7] The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or

[7] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995) at 314-315.

silicotuberculosis.[8] 20 C.F.R. § 718.201. The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment". This broad definition effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing*, *Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980). Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrefutable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician

---

[8] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

(Emphasis added).

exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[9] 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, *i.e.* x-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

As stated below, I find that the claimant has established pneumoconiosis pursuant to subsection 718.202(a)(2) by biopsy evidence. While several physicians of record found radiographic evidence of complicated pneumoconiosis, I find that Mr. Price has failed to show the existence of complicated pneumoconiosis, since Mr. Price's more recent X-ray readings, specifically those readings after his October 1999 lobectomy, show no evidence of complicated pneumoconiosis. Moreover, equally qualified readers submitted reports contradicting the findings of complicated pneumoconiosis, noting that the large mass seen in Mr. Price's upper right lung zone was likely cancer. Thereafter, Mr. Price had a lobectomy to remove a malignant mass in his right upper lung zone. Accordingly, I find that there is insufficient evidence of record to establish complicated pneumoconiosis, as required by the Act and Regulations.

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence.[10] 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). "[W]here two or more x-ray reports are in conflict, in evaluating such x-ray reports, consideration shall be given

---

[9] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel*, 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

[10] "There are twelve levels of profusion classification for the radiographic interpretation of simple pneumoconiosis. 2/3 is the fourth highest profusion and 3/2 the third. *See* N. LeRoy Lapp, "A Lawyer's Medical Guide to Black Lung Litigation," 83 *W. Va. Law Review* 721, 729-731 (1981)." Cited in *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1359, n. 1.

to the radiological qualifications of the physicians interpreting such x-rays." *Id.; Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985)."(Emphasis added). Readers who are Board-Certified Radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985).

A judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). The ALJ must rely on the evidence which he deems to be most probative, even where it is contrary to the numerical majority. *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984).

In addition, the Fourth Circuit holds that a judge may afford more weight to recent medical evidence. *Adkins v. Director, OWCP*, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). In *Lane Hollow Coal Co. v. Director, OWCP [Lockhart]*, 21 B.L.R. 2-302, 137 F.3d 799, (4th Cir., Mar. 3, 1998), the Court noted that pneumoconiosis is a progressive and irreversible disease such that it is proper to accord greater weight to later positive x-ray studies over earlier negative ones. Generally, "later evidence is more likely to show the miner's current condition" where it is consistent in demonstrating a worsening of the miner's condition. It is rational to credit more recent evidence, solely on the basis of recency, only if it shows the miner's condition has progressed or worsened. The court reasoned that, because it is impossible to reconcile conflicting evidence based on its chronological order if the evidence shows that a miner's condition has improved, inasmuch as pneumoconiosis is a progressive disease and claimants cannot get better, "[e]ither the earlier or the later result must be wrong, and it is just as likely that the later evidence is faulty as the as the earlier. . ." *See also, Thorn v. Itmann Coal Co.*, 3 F.3d 713, 18 B.L.R. 2-16 (4th Cir. 1993).

In the present matter forty one X-ray readings of eight X-rays, from October 9, 1986, to November 27, 1999, were submitted. Of the forty one readings, twenty five readings were interpreted as negative for pneumoconiosis and sixteen readings were interpreted as positive for pneumoconiosis. More specifically, the first X-ray, dated October 9, 1986, was interpreted as negative for pneumoconiosis, by one B-reader and one dually-qualified physician. The second X-ray, dated June 4, 1999, was interpreted as positive for pneumoconiosis by two dually-qualified physicians, one B-reader and one non-qualified reader, however, three dually-qualified physicians interpreted the X-ray as negative for pneumoconiosis. More significantly, one dually-qualified physician and one B-reader interpreted the X-rays as positive for category "A" complicated pneumoconiosis. The third X-ray, dated September 22, 1999, was interpreted as positive for pneumoconiosis by four B-readers and one dually-qualified physician, with two of the B-readers finding evidence of complicated pneumoconiosis. The same X-ray was interpreted as negative for pneumoconiosis by three dually-qualified physicians. The fourth X-ray, dated October 12, 1999, was interpreted as negative for pneumoconiosis by one B-reader and was interpreted as positive for pneumoconiosis by two B-readers and one dually-qualified physician, with two B-readers finding evidence of complicated pneumoconiosis. The fifth X-ray, dated October 16, 1999, was

interpreted as negative for pneumoconiosis by two B-readers and four dually-qualified physicians. The sixth X-ray, dated October 23, 1999, was interpreted as negative for pneumoconiosis by two dually-qualified physicians and one B-reader. The seventh X-ray, dated November 16, 1999, was similarly interpreted as negative for pneumoconiosis by two dually-qualified physicians and one B-reader. The eighth X-ray, dated November 27, 1999, was interpreted as positive for pneumoconiosis by two B-readers and three dually-qualified physicians, however, five dually-qualified readers and two B-readers interpreted the same X-ray as negative for pneumoconiosis.

Moreover, four CT readings, dated October 12, 1999, were submitted. The CT scan was taken prior to Mr. Price's lobectomy, and therefore, three of the four reviewing physicians noted the presence of a cavitary mass in the upper right lobe with nodules seen throughout his lungs. However, none of the physicians affirmatively noted the presence of pneumoconiosis in their reading of the CT scan.

Although the majority of the most recent X-ray readings, made by the most qualified readers, were negative for pneumoconiosis, I find that these readings are inconsistent with the findings set forth in Mr. Price's pathology report. More specifically, Mr. Price's October 21, 1999 pathology report, showed evidence of anthracosis in his lymph nodes and upper right lobe. (DX 50). Accordingly, I have given little lesser weight to the radiographic evidence of record.

Additionally, a determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a). Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contraindicates it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

In the present matter, conflicting medical reports were submitted regarding Mr. Price's pulmonary condition. While Drs. Walker and Ranavaya concluded that Mr. Price had pneumoconiosis, Drs. Zaldivar and Altmeyer found no physical or radiographic evidence of pneumoconiosis. [11] Although Drs. Zaldivar and Altmeyer are more qualified than Drs. Walker and Ranavaya, in that they are both B-readers and board-certified in internal medicine and pulmonary diseases, I find that their opinions are contradicted by the objective medical evidence

[11] While Dr. Zaldivar originally concluded that Mr. Price had pneumoconiosis in his report dated September 22, 1999, Dr. Zaldivar changed his conclusion after reviewing a more recent chest X-ray of Mr. Price, which was taken afer his 1999 lobectomy.

of record. Most notably, the pathology report, dated October 21, 1999, submitted by Richard M. Faulks, M.D., showed evidence of anthracosis in Mr. Price's lymph nodes and upper right lobe. (DX 50). The regulations provide that:

> (c) A negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive findings are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis.
>
> (d) 20 C.F.R. §718.106(c).[12] Moreover, Dr. Zaldivar did not mention the findings contained in the pathology report in his medical report. While Dr. Altmeyer mentioned the pathology report, he stated that it did not establish the existence of pneumoconiosis, since the report showed no evidence of silicosis. This opinion is without merit, since Mr. Price's pathology report showed evidence of anthracosis, which is included in the clinical definition of pneumoconiosis as set forth in the regulations.[13] For these reasons, I do not give the opinions of Drs. Altmeyer and Zaldivar much weight. [14] Accordingly, I find that Mr. Price has established, by a preponderance of the evidence, that he has pneumoconiosis.

D. Cause of pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine

---

[12] Even though 20 C.F.R. § 718.106(b) states that 'no report of [a] biopsy submitted in connection with a claim shall be considered unless the report complies with the requirements of this section,' ... the director has interpreted this section to require only substantial compliance..." *Dagnan v. Black Diamond Coal Mining Co. & Director, OWCP*, 994 F.2d 1536, 1540 (11th Cir. 1993). *Citing Director, OWCP, v. Mangifest*, 826 F.2d 1318, 1326 n. 3 (3rd Cir. 1987)(quoting 20 C.F.R. § 718.106(b)). The court also noted that the Board "construes the standards for admissibility set out in 20 C.F.R. § 718.106(b) to be only guidelines and not mandatory. *See, e.g., Dillon v. Peabody Coal Co.*, 11 B.L.R. 1-113, 1-114, 1-115 (1988). However, I find that the surgical pathology report in the instant matter complies with the regulatory requirements set forth in 20 C.F.R. § 718.106(b).

[13] "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, **anthracosis**, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

[14] Although a report cannot be discredited simply because a physician did not consider all medical data of record, it is proper to accord greater weight to an opinion which is better supported by the objective medical data of record, *i.e.*, x-ray, blood gas, and ventilatory studies. *Minnich v. Pagnotti Enterprises, Inc*., 9 B.L.R. 1-89, 1-90 n. 1 (1986); *Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985).

employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since I have found that the claimant was a miner for at least seventeen years the claimant receives the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment.

E. Existence of total disability

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[15] Sections 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony.[16] Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miner's claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). More weight may be accorded to the

---

[15] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states:

(a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

[16] In a living miner's claim, lay testimony "is not sufficient, in and of itself, to establish disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). See also 20 C.F.R. § 718.204(d)(5)(living miner's statements or testimony insufficient alone to establish total disability).

results of a recent blood gas study over one which was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993).

In the instant matter, five pulmonary function studies were submitted and the four most recent studies had qualifying results, and therefore, showed evidence of a total respiratory disability. Additionally, four arterial blood gas studies were submitted. Of the four arterial blood gas studies, only the most recent study, dated September 22, 1999, was qualifying. Accordingly, I find that the majority of the most recent pulmonary function studies and arterial blood gas studies establish that Mr. Price suffered from a total respiratory disability.

In addition, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b). Under this subsection, " . . . all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Camp Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

While only Dr. Walker opined that Mr. Walker suffered from total respiratory disability, I find that his opinion is more consistent with the more recent objective medical data of record, and therefore, I have afforded his opinion more weight. It is well settled that, although a report cannot be discredited simply because a physician did not consider all medical data of record, it is proper to accord greater weight to an opinion which is better supported by the objective medical data of record, *i.e.*, x-ray, blood gas, and ventilatory studies. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n. 1 (1986); *Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985). Although Drs. Zaldivar and Altmeyer concluded that Mr. Price only suffered from a mild to moderate respiratory impairment, Dr. Zaldivar admitted that Mr. Price would require bronchodilators on a chronic basis to perform manual labor and Dr. Altmeyer did not address the qualifying diagnostic test results. Accordingly, I do not find that Drs. Altmeyer and Zaldivar effectively ruled out a diagnosis of a total respiratory disability. Furthermore, I have given little weight to Dr. Ranavaya's report, since he provided no explanation for his conclusion that Mr. Price did not have a total respiratory disability, despite his qualifying diagnostic test results. Accordingly, I find that Mr. Price has established, by a preponderance of the evidence, that he had a total respiratory disability.

F. Cause of total disability[17]

The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 79946 (Dec. 20, 2000).[18]

The Board requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(*en banc), overruling Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988). Additionally, the Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability.[19] *Toler v. Eastern Associated Coal Co.*, 43 F. 3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respiratory or pulmonary impairment that is totally disabling and whether [the claimant's pneumoconiosis contributes to this disability." *Street*, 42 F.3d 241 at 245.

In the instant matter, Dr. Walker opined that Mr. Price's total respiratory disability was the caused by his coal workers' pneumoconiosis and his history of cigarette smoking. To qualify for Black Lung benefits, the claimant need not prove that pneumoconiosis is the "sole" or "direct" cause of his respiratory disability, but rather that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (CA4

---

[17] *Billings v. Harlan #4 Coal Co.*, ___ B.L.R. ___ , BRB No. 94-3721 (June 19, 1997). The Board has held that the issues of total disability and causation are independent; therefore, administrative law judges need not reject a doctor's opinion on causation simply because the doctor did not consider the claimant's respiratory impairment to be totally disabling.

[18] Effective January 19, 2001, § 718.204(a) states, in pertinent part:

> For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

[19] *Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). Under *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, *914 F.2d 35* (4th Cir. 1990), the terms "due to," in the statute and regulations, means a "contributing cause.," not "exclusively due to." In *Roberts v. West Virginia C.W.P. Fund & Director, OWCP*, 74 F.3d 1233 (1996 WL 13850)(4th Cir. 1996)(Unpublished), the Court stated, "So long as pneumoconiosis is a 'contributing' cause, it need not be a 'significant' or substantial' cause." Id.

1990) at 2-76, *914 F.2d 35*. [20] I have afforded more weight to the opinion of Dr. Walker, since his opinion is more consistent with the objective medical data of record versus of the opinions of Drs. Ranavaya, Zaldivar and Altmeyer.

While Drs. Zaldivar, Altmeyer and Ranavaya all concluded that Mr. Price's respiratory impairment, if any, was not caused by pneumoconiosis, I find that their opinions have little probative value. First, Dr. Ranavaya failed to provide any medical reasoning for his conclusion that Mr. Price's respiratory impairment was not caused by pneumoconiosis, and therefore, I find his opinion is without merit. Second, as stated earlier, Dr. Altmeyer erroneously found that Mr. Price's pathology report showed no evidence of pneumoconiosis, even though the report noted the presence of anthracosis in Mr. Price's lymph nodes and upper right lung. While it is unclear from the record, whether Dr. Zaldivar was given the opportunity to review Mr. Price's pathology report, in his supplemental report, Dr. Zaldivar opined that Mr. Price showed no evidence of pneumoconiosis. Recently, in *Scott v. Mason*, __F.3d__, Case No. 99-1495 (4th Cir. May 2, 2002), the Fourth Circuit held that an ALJ erred accordingly greater weight to opinions of Drs. Dahhan and Castle, who found that the miner's disability was not due to pneumoconiosis, because they had concluded he did not suffer from pneumoconiosis, contrary to the ALJ's findings. Similarly, in *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995), the court held that, where the administrative law judge determines that a miner suffers from pneumoconiosis or is totally disabled or both, then a medical opinion wherein the miner is determined not to suffer from pneumoconiosis or is not totally disabled "can carry little weight" in assessing the etiology of the miner's total disability "unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability causation does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates (pneumoconiosis and total disability) in the causal chain." Accordingly, I have given little weight to opinions of Drs. Altmeyer and Zaldivar, since neither physician stated that their opinions regarding causation would be the same, even if they had found evidence of pneumoconiosis. Therefore, I find that Mr. Price has established, by a preponderance of the evidence, that his total respiratory disability was the result of his pneumoconiosis, as required by the Act and Regulations.

G. Death due to Pneumoconiosis

Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that death will be due to pneumoconiosis if any of the following criteria are met:

[20] The fact that a physician does not explain how he could distinguish between disability due to coal mining and cigarette smoking or refer to evidence which supports his total disability opinion, may make his opinion unreasoned. *Gilliam v. G&O Coal Co.*, 7 B.L.R. 1-59, 1-61 (1984). However, since Dr. Walker's was supported by the objective medical evidence of record, I find his opinion well reasoned.

> (1) competent medical evidence established that the miner's death was due to pneumoconiosis; or
>
> (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or
>
> (3) the presumption of § 718.304 [complicated pneumoconiosis] is applicable.

The Board concludes that death must be "significantly" related to or aggravated by pneumoconiosis, while the circuit courts have developed the "hastening death" standard which requires establishment of a lesser causal nexus between pneumoconiosis and the miner's death. *Foreman v. Peabody Coal Co.*, 8 B.L.R. 1-371, 1-374 (1985). The United States Court of Appeals for the Third Circuit has held that any condition that *hastens* the miner's death is a substantially contributing cause of death for purposes of § 718.205. *Lukosevicz v. Director, OWCP*, 888 F.2d 1001 (3d Cir. 1989). The Fourth Circuit has adopted this position in *Shuff v. Cedar Coal Co.*, 967 F.2d 977 (4th Cir. 1992), *cert. den.* 506 U.S.1050, 113 S.Ct. 969 (1993).

Survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. § 718.205(c)(4). *Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988) (survivor not entitled to benefits where the miner's death was due to a ruptured abdominal aortic aneurysm).

The Act and Regulations do not require that pneumoconiosis be the sole, primary or proximate cause of death, but rather that where the principal cause of the miner's death was not pneumoconiosis, that the evidence establish it was a "substantially contributing cause." 20 C.F.R. § 718.205(c)(4). *See, Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 1005 (3rd Cir. 1989)(quoting 48 Fed. Reg. 24,276, 24,277(1), (n)(1983)). In *Richardson v. Director, OWCP*, 94 F.3d 164, 167 (4th Cir. 1996), the Fourth Circuit Court of Appeals stated that, in a survivor's claim under Part 718, Claimant must demonstrate that pneumoconiosis "hastened" the miner's death "in any way."

In the instant matter, Mrs. Price failed to present any competent medical evidence that pneumoconiosis was a significant contributing factor to her husband's death. Accordingly, I find

that Mrs. Price has failed to establish, by a preponderance of the evidence, that she is entitled to survivor's benefits.

H. Date of entitlement[21]

Benefits are payable beginning with the month of the onset of total disability due to pneumoconiosis.[22] 20 C.F.R. § 725.503. Since no specific onset date of disability is evident from the record, benefits will begin on the first day of the month in which he filed this claim. 20 C.F.R. § 725.503(b). The decedent-claimant filed his claim for benefits on March 24, 1999. (DX 1). Therefore, the decedent-claimant in entitled to benefits starting March 1, 1999.

I. Attorney fees

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits were awarded in this case, thirty days is hereby allowed to the claimant's counsel for the submission of such an application. Counsels' attention is directed to 20 C.F.R. §§ 725.365- 725.366. A service sheet showing that service has been made upon all the partes, including the claimant, must accompany the application. Parties have ten days following receipt of any such application within which to file any objections. The Act prohibits charging of a fee in the absence of an approved application.

CONCLUSIONS

In conclusion, the decedent-miner, James H. Price, established by a preponderance of the evidence, that he had pneumoconiosis and that he was totally disabled as a result of pneumoconiosis, and therefore, he is entitled to an award of benefits under the Act and Regulations. However, his survivor, Evelyn K. Price, failed to establish that pneumoconiosis significantly contributed to her husband's death, to warrant entitlement to survivor benefits.

---

[21] 20 C..R. § 725.503(g) provides: "Each decision and order awarding benefits shall indicate the month from which benefits are payable to the eligible claimant."

[22] The date of the first medical evidence of record indicating total disability does not establish the onset date; rather, such evidence only indicates that the miner became totally disabled at some prior point in time. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984); *Hall v. Consolidation Coal Co.*, 6 B.L.R. 1-1310 (1984).

ORDER

It is hereby ORDERED that the claim of the decedent-miner, James H. Price, for living miner's benefits under the Black Lung Benefits Act is hereby GRANTED.

It is additionally ORDERED that the claim of Evelyn K. Price for survivor's benefits under the under the Black Lung Benefits Act is hereby DENIED.

A

RICHARD A. MORGAN
Administrative Law Judge

RAM:ALS:dmr

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits review Board within 30 days from the date of this Order by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601**. A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C.

APPENDIX "A"

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression4/5/00
DX 30-6	10/9/86 11/10/86	Sargent	B, BCR	2	_	
DX 30-7	10/9/86 10/11/86	Gaziano	B	1	_	
DX 13	6/4/99 7/1/99	Navani	B, BCR	2	1/1	p and s opacities in all 6 lung zones
DX 29	6/4/99 12/8/99	Shipley	B, BCR	1	_	5 cm cavitary lesion in right upper lung zone
DX 28	6/4/99 11/4/99	Wiot	B, BCR	1	_	Cavitary lesion, likely carcinoma
DX 28	6/4/99 11/27/99	Spitz	B, BCR	1	_	Cavitary lesion, right upper lung zone
DX 14	6/4/99 6/8/99	Hayes		1	1/1	q and p opacities in all 6 lung zones
CX 10	6/4/99 9/21/00	Pathak	B	1	2/2	Complicated pneumo, Category A. Cavitary mass right upper lob
CX 7	6/4/99 9/25/00	Ahmed	B, BCR	2	2/1	Complicated pneumo, Category A. 5 cm lesion upper right lung, could be complicated pneumo or cancer.
CX 11	6/4/99 9/28/00	Aycoth	B	1	1/1	4 cm. mass upper left lobe. Scattered round opacities measuring up to 1.5 cm.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression4/5/00
DX 25	9/22/99 11/21/99	Zaldivar	B	1	1/1	Cavitary mass right upper lung zone
EX 3 DX 32	9/22/99 2/14/00	Wiot	B, BCR	1	_	Cavity mass in upper right lobe
EX 2 DX 35	9/22/99 3/19/00	Shipley	B, BCR	1	_	Right upper lung lesion, likely cancer, no CWP
DX 35	9/22/99 3/25/00	Spitz	B, BCR	1	_	Cavitary lesion, right upper lobe
CX 4	9/22/99 5/02/00	Pathak	B	1	2/2	Complicated pneumo - Category B. Large 6.5 x 5.5 c.m thick walled cavity in upper right lobe. COPD
CX 3	9/22/99 4/28/00	Aycoth	B	1	2/2	Category A opacities. Right upper lobe cavitation can be associated with neoplasm, TB, or fungal or bacterial disease
CX 1	9/22/99 4/21/00	Ahmed	B, BCR	1	½	Emphysema.. 6 cm cavitary right upper lung lesion with air fluid level, could be tumor, fibrosis or abscess.
CX 2	9/22/99 4/26/00	Miller	B	1	1/1	Right upper lung cavitary lesion requires further evaluation
CX 6	10/12/99 9/25/00	Ahmed	B, BCR	2	2/1	Emphysema, cavitation
DX 35 EX 1	10/12/99 4/24/00	Zaldivar	B	2	_	

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression4/5/00
CX 10	10/12/99 9/21/00	Pathak	B	1	2/2	Complicated pneumo, Category B. Lg. 5 x 4 cm. cavitary mass right upper lobe. Rec. CT Scan.
CX 11	10/12/99 9/28/00	Aycoth	B	1	1/2	Complicated pneumo, Category A. 5 cm calcification in upper right lobe.
EX 2	10/16/99 10/4/02	Smith, R	B, BCR	Not Provided	_	
EX 5	10/16/99 11/7/02	Willis	B	1	_	Cavitary mass RUL
EX 3	10/16/99 10/03/02	Smith, J	B, BCR	1	_	probable abscess
EX 3	10/23/99 10/03/02	Smith, J	B, BCR	1	_	atelectatic changes both bases
EX 5	10/23/99 10/7/02	Willis	B	1	_	
EX 2	10/23/99 10/4/02	Smith, R	B, BCR	Not Provided	_	
EX 3	11/6/99 10/03/02	Smith, J	B, BCR	1	_	
EX 5	11/6/99 10/7/02	Willis	B	1	_	
EX 2	11/6/99 10/4/02	Smith, R	B, BCR	1	_	
EX 1 DX 35	11/27/99 4/24/00	Zaldivar	B	2	_	
EX 1	11/27/99 8/10/02	Wiot	B, BCR	3	_	

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression4/5/00
CX 8	11/27/99 9/25/00	Ahmed	B, BCR	2	2/1	Simple pneumo, emphysema. Cavitary lesion previously seen removed.
CX 10	11/27/99 9/21/00	Pathak	B	1	2/2	Pneumo and COPD
CX 11	11/27/99 9/28/00	Aycoth	B	1	1/1	Scattered rounded opacities up to 1.5 cm.
EX 1	11/27/99 8/22/02	Shipley	B, BCR	3	_	
EX 2	11/27/99 9/23/02	Spitz	B, BCR	2	_	
EX 3	11/27/99 10/03/02	Smith, J	B, BCR	1	_	
EX 4	11/27/99 10/04/02	Smith, R	B, BCR	1	_	
EX 5	11/27/99 10/7/02	Willis	B	2	_	
CT SCANS						
CX 5	10/12/99 9/25/00	Ahmed	B, BCR	2		soft rounded parenchymal densities measuring up to 3 cm scattered throughout both lungs. Cavity in upper right lung with nodularity, either a cavitating lung neoplasm or progressive massive fibrosis

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression4/5/00
CX 10	10/12/99 9/21/00	Pathak	B			Thick walled cavity with large intramural nodule undergoing percutaneous biopsy from a posterior approach
CX 11	10/12/99 9/28/00	Aycoth	B			Non-specific CT examination of the thorax
EX 1 DX 35	10/12/99 4/24/00	Zaldivar	B	2		Nodules present throughout

* A- A-reader; B- B-reader; BCR- Board-Certified Radiologist; R- Radiologist; BCP-Board-Certified Pulmonologist; BCI- Board-Certified Internal Medicine; BCCC- Board-Certified Critical Care. Readers who are board- certified radiologists and/ or B-readers are classified as the most qualified. B-readers need not be radiologists.

** The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). ILO-UICC/Cincinnati Classification of Pneumoconiosis - The most widely used system for the classification and interpretation of x-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labour Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs. In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983)(Decided under Part 727 of the Regulations).